REGISTRATION FORMS

Patient Name: First Middle Last					Home Phone Number:		
Home Address: Apt. No.			City:		State	Zip Code:	
Occupation:	Relationship Status:		Date of Birth:		Age:	Gender:	Pronouns:
E-mail address:		Cell Phone:					
Employer:	Address:		Work Phone Number:				
Partner (or parent) name:							
Partner (or parent) employer:			Work Phone Number:				
Family Physician:	Address:		Phone:				
Referring Physician:	Address:		Phone:				
How did you hear about us?							

BILLING AND INSURANCE INFORMATION

PRIMARY INSURANCE	Insurance Company Name:		ID or Policy Number:	Group / Code:
	Subscriber's Name:		Date Effective:	
	Subscriber's Date of Birth:	Sex:	Home Phone Number:	Relationship to Patient:

Do you have any other Insurance? Yes No (If yes, please specify)__________________

A message: ☐ can ☐ can not be left on my home phone or cell phone. (Please check a box.)

PRIVACY CONSENT

Rebecca Bitzer, M.S., R.D. & Associates, Inc. ("RBA") has implemented policies and procedures so that the confidentiality of your personal and medical information remains confidential. RBA requires your consent to use and disclose your protected health information to carry out treatment, payment and health care operations. If you would like a more detailed description of such uses and disclosures please refer to our Notice of Privacy Practices. You have the right to review our Notice of Privacy Practices before signing this Consent. The terms of our Notice of Privacy Practices of RBA may change from time to time. You can get a copy of our revised Notice of Privacy Practices by contacting our office at 301-474-2499. We will also post a copy of our current Notice of Privacy Practices in our office.

You have the right to revoke this consent in writing at any time, except to the extent that the use or disclosure has been made prior to your revocation and RBA has acted in reliance on your consent.

Further, you acknowledge that you have an opportunity to discuss with the Registered Dietitian and/or with other office personnel, the nature and purpose of medical nutrition therapy. You understand the results are not guaranteed. You give RBA permission to send a summary note to your physician or referring doctor of the consultation here.

By signing below, you hereby consent to our use of your protected health information for treatment, payment and health care operations and acknowledge receipt of a copy of this Consent, if requested. You hereby release RBA from any legal responsibility or liability for disclosure that may arise as a result of the use or release of the information contained in your protected health information.

Printed Name: ____

Signature: ______________________________________ Date: ____________________

POLICIES

Thank you for choosing Rebecca Bitzer, M.S., R.D. & Associates, Inc. ("RBA"). Medical Nutrition Therapy ("MNT") is covered by many insurance plans. By signing below, you agree to these terms. We will use your insurance benefits when possible. MNT is defined as face-to-face medically necessary nutrition counseling. We will also provide additional non-covered services when necessary to help you meet your nutrition goals. Here are our billing terms:

1. If using health insurance benefits:
    a. You hereby authorize RBA to apply for benefits on your behalf for covered services rendered. You certify that all information given to RBA is correct, and authorize the filing of claims and release of all information, including medical information for this or related claims. You authorize RBA to share information about you and your treatments for payment processing and as otherwise provided in our Privacy Notice. Further, you authorize RBA to receive benefits when a claim is filed, to appeal any denials and to otherwise deal directly with your insurance company.
    b. If required by your insurance, it is your responsibility to bring a proper referral (and/or obtain any required pre-authorization) and copay to your appointment.
    c. You understand that RBA may verify your benefits prior to your appointment, however, that is not a guarantee of coverage and it is ultimately your responsibility to be aware of your coverage, limitation and exclusions before the time of service. You understand that if your insurance company does not cover MNT for any reason (including a lack of any needed referral or pre-authorization), you will be responsible for all non-covered services rendered. If RBA is uncertain of coverage, RBA will keep a deposit or credit card on file until it is compensated by the insurance company.
2. All fees are due at the time of service or when invoiced. Patients must have a zero balance in order to be seen. Additional fees may apply, including the following:
    a. There will be a $25 fee for any returned checks.
    b. RBA has a policy for missed or cancelled appointments. Cancellations or missed appointments with less than 2 business days' notice (48 hours from appointment time) will be charged a $40 fee. Business days are Monday through Friday, 9:00 to 5:00.
    c. There will be a 15% fee added to any outstanding balances that are 30 days overdue, 30% added to any outstanding balances that are 60 days past due and 45% to any outstanding balances that are 90 days past due. Any outstanding balances after 90 days may be referred to an outside collection agency. Patients with continually delinquent accounts or those whose accounts have been sent to a collection agency are subject to discharge from RBA. If any of RBA's directors, officers, employees or stockholders are asked to be involved in any legal matter requiring participation pertaining to you or your child via telephone, court deposition and/or court appearance, RBA will charge a fee for those services. This will include preparation time, professional time and transportation costs. The fee for these services of two hundred fifty dollars ($250.00) per hour will be billed to the patient whose attorney is requesting the information.
3. Self-Pay Services:

    RBA has discounted, prompt pay fees available. These services are available to you if your insurance does not cover your nutrition counseling or if your Registered Dietitian Nutritionist advises non-covered services. The self-pay services are as follows:

    a. Nutrition Counseling either in person or via telehealth
        i. Basic Self-Pay Packages (SPP)
            1. Initial session ($175)
            2. 3 Visit Self Pay Package ($390)
            3. 3 Visit Couples Self Pay Package $531
        ii. Specialized Services
            1. Daily Remote Monitoring $250/month
            2. Eating disorder Coordination of Care Fee $75/session
            3. Phone call with dietitian $25
            4. Customized Meal Plans $250
    b. Testing
        i. RMR Metabolism Testing based on insurance benefits $50
        ii. Body Fat Analysis $50
        iii. RMR metabolism Testing and the Body Fat Analysis package $75
        iv. MRT/LEAP food sensitivity testing $435 + $25 for blood sample collection.
        v. SpectraCell $275- $475 (estimated patient co-pay portion, assuming balance paid through patient insurance, full test charge: $_______ – please note: Spectracell does <u>not</u> accept Medicaid).
        vi. Nutrigenomix Saliva Test $395
        vii. Genova Stool Testing if BCBS, Cigna or UHC $171.

4. Nutrition Disclaimer and Acknowledgement:

    You understand that RBA provides dietitian and nutritional services as Registered Dietitians, and not medical physicians. You further acknowledge and agree that RBA does not, and will not, dispense medical advice or diagnose or treat any medical conditions, but rather, will exclusively provide nutritional support and nutrition education for conditions diagnosed by a third-party medical professional.

5. Food Allergies/Sensitivities:

You acknowledge and agree that specific foods may create allergic and possible fatal reactions, for example, but without limitation, products containing nuts. You hereby agree to disclose any food allergies/sensitivities that you are aware of. You are aware that specific foods may interact with certain medications. You have discussed the side effects of all of your medications with your doctor or pharmacist. You hereby release RBA, its directors, officers, employees and stockholders from any legal responsibility or liability for recommending or providing certain foods after relying on your disclosure of known food allergies/sensitivities.

6. Supplements:
   You acknowledge and agree that any advice regarding dietary supplements provided by RBA is strictly done so by opinion only, and these products may not have been approved by the FDA. You acknowledge that any companies or products mentioned by RBA are not affiliated with RBA and RBA, its directors, officers, employees and stockholders are not liable for any claims relating or arising therefrom.

7. RBA reserves the right to change these terms at any time. You may obtain a revised copy of these terms by submitting a written request to our office, by emailing us or by requesting in person at our office.

8. How We Will Communicate With You:

   Use of Telephone:

   If you provide us with a telephone number, we may contact you using that telephone number to discuss your services, appointments, records, and purchases.

   Use of Electronic Communication Methods:

   Electronic communications include email messages, internet communication services (such as Skype™), or other electronic methods. You agree that electronic communications are not secure and that there is the possibility that they may be accessed by other persons. You also agree that your employer may review any electronic communications transmitted through your employer's computer system. We may use email or other electronic communications to transmit routine information to you (such as appointment dates, newsletters, etc.). We may also use email or other electronic communications to transmit information concerning your services and products, unless you tell us otherwise (as described below). If you give us an email address or communicate with us using other electronic communications, you agree that: (a) electronic communications should not be used for emergency or other time-sensitive situations or where sensitive information will be transmitted (please contact us by telephone or visit our location); (b) we will use reasonable efforts to respond to electronic communications that you send (if you do not hear from us within 2 business days, please contact us by telephone or visit our location) and we will not be liable for any failure to respond or any intercepted electronic communications; (c) one or more of our staff members may need to access your electronic communications in order to help us respond; and (d) we may keep copies of electronic communications that you send in your patient records.

   If you do not wish us to use electronic communications to transmit information concerning your services/products, you can provide written notice to us at admin@rbitzer.com or at 301-474-2499.

You acknowledge and agree that you accept all of the above terms in the Policies.

Signature ____

Date__________________________________

Credit Card Payment Authorization:

Please sign below to authorize Rebecca Bitzer, M.S., R.D. and Associates, Inc. to use this credit card for fees and charges related to your RBA services/products. Your authorization will remain in effect until you cancel it by calling us at 301-474-2499 or emailing us at admin@rbitzer.com..

Account Type: Visa MasterCard American Express Discover

Cardholder Name: ____

Credit Card Number: ___________

Expiration Date: ___________________

CSV Code:_________

I authorize RBA to use the above credit card to pay for services, products or other fees. I understand that I am financially responsible for all charges for services rendered on my behalf or on behalf of my dependent.

____ ____________________

Patient Signature Date

Health History	
List Your Main Health Concerns (In order of importance)	Duration of Problem
1.	
2.	
3.	
4.	
5.	

Please Circle Yes or No to the Questions Below		
Do you make yourself sick because you feel full?	YES	NO
Do you worry you have lost control over eating?	YES	NO
Have you recently lost more than 14 lbs during the last 3 months?	YES	NO
Do you believe you are fat when others say you are too thin?	YES	NO
Would you say food dominates your life?	YES	NO
Are you satisfied with your eating patterns?	YES	NO
Do you ever eat in secret?	YES	NO
Do you have regular bowel movements?	YES	NO

Please list all surgeries		
1.	2.	3.

Circle (or Write In) All Medical Conditions Previously Diagnosed and/or Symptoms				
Diabetes	Anorexia	Inflammatory Bowel Disease (IBD)	Chronic Kidney Disease (CKD)	Migraines/ headaches
High Cholesterol	Bulimia	Irritable Bowel Syndrome (IBS)	Cancer	Arthritis
Hypertension	Binge Eating	Celiac Disease	Bloating/ Distention	Eczema/ skin diagnosis
PCOS	Food Cravings	Lactose Intolerance	Joint Pain	Fatigue
Sleep Apnea	Depression	Diarrhea	Other:	Insomnia
Infertility	Anxiety	Constipation	Other:	Other:
Food Allergies	Emotional Eating	Gas/ Belching	Other:	Other:
Heartburn/ GERD	Attention Deficit Disorder	Nausea/Vomiting	Other:	Other:

List All Medications You Currently Take <u>Regularly OR As Needed</u> (Prescription & OTC)			
Drug	Dosage	# Times Per Day	Start Date

Height:	Weight:	Do you consider yourself: Underweight Overweight. Just Right
List family medical history:		
Is there any other medical information concern you that we should be aware of?		
List all vitamins, minerals, and/or supplements:		
List any allergies (food and environmental):		

Are you interested in any of the following? Please circle:			
Glucose Meter Testing Training	Metabolism Testing	Body Fat Testing	Vitamin and Mineral Deficiency Testing
Food Sensitivities testing	Stool testing	Genetic Testing	Cardiometabolic Testing

NUTRITION ASSESSMENT	
List any goals you hope to achieve as a result of nutrition counseling:	
Have you ever worked with a dietitian/nutritionist? Yes _____ No______	If yes, who:
Are you currently engaged in a regular exercise program? If yes, please describe and how often:	
How many hours of sleep do you get? Any issues falling asleep?	
Stress Level: 1-10 (10 being the highest):	
Do you cook? Yes ______ No_____	
Please add any other comments that you would like us to know:	

FOOD QUESTIONNAIRE
What are your favorite foods?
What are your least favorite foods?
How many times PER WEEK do you eat the following meals out? (fast food, take out, restaurants) Breakfast:______ Lunch: _______ Dinner: ______
Do you avoid any foods? Why?
Alcohol/ drug consumption?

Please record what you ate and drank yesterday			Location (Kitchen, car, work, living room, etc.)
	Time	Food eaten (Describe)	
Breakfast			
Lunch			
Dinner			
Snacks			

AUTHORIZATION TO OBTAIN/ RELEASE CONFIDENTIAL INFORMATION

I, ___________________________ authorize Rebecca Bitzer, M.S., R.D. and Associates, Inc. to

- Discuss my treatment progress
- To obtain medical records and/or progress notes
- To release medical records and/or progress notes

With/To/From the following individuals:

Primary Doctor:

Name: ______________________________________ Address: ____

Phone: _____________________________________ Email:____

Therapist:

Name:_______________________________________ Address:____

Phone: ______________________________________ Email:____

Treatment Center:

Name:_______________________________________ Address:____

Phone:______________________________________ Email:____

Other:

Name:______________________________________ Address:____

Phone:_____________________________________ Email:____

I understand that my records and treatment are confidential and will not be disclosed without my written consent unless under legal compulsion. I agree that RBA is not responsible for any action or adverse consequence related to the release of this information and is not required to verify the validity of the information above. I hereby release RBA from any legal responsibility or liability for disclosure that may arise as a result of the use or release of the information contained in the protected health information. I also understand that I may revoke this consent in writing at any time, except to the extent that action has been made prior to the revocation and in reliance therein.

Date :____ Patient Signature:____

Address:____

Parent/Guardian Signature:____

Dietitian Signature:____

Authorization and Consent to Treat Minor Child

I, _________________[Full Legal Name of Parent/Guardian], being the parent/legal guardian of _________________[Child's Full Name] authorize _________________[Full Name of Caregiver] to seek, obtain and consent to [routine medical care and treatment/emergency medical care and treatment/ surgery/hospitalization/blood transfusions/dental care and treatment/other] for _________________[Child's Full Name] as deemed necessary by a licensed medical or healthcare professional. This authorization is for the time period when my child is in the care of _________________[Full Name of Caregiver], my child's _________________[Relationship to Child (e.g. grandmother, grandfather, aunt, uncle, nanny, baby-sitter, family friend, teacher)] and is effective during such period as I may for any reason not be available to give my consent to any treatment for my child.

Child's Information

Child's Full Name: ____
Address: ____
Date of Birth: _________________________ Age: __________________________

Parent/Guardian's Information

Parent's/Guardian's Name 1: ____
Address: ____
Phone Number (H): _____________________ Phone Number (C): ________________
Email Address: _______________________

Parent's/Guardian's Name 2: ____
Address: ____
Phone Number (H): _____________________ Phone Number (C): ________________
Email Address: _______________________

Child's Health Information

Health Conditions (e.g. Asthma, Diabetes): ___________________________________
Allergies (e.g. to Medications, Food): _______________________________________
Prescription Medications: ____
Date of Last Tetanus Injection/Booster: ______________________________________

Child's Medical Care and Insurance Information

Physician/Pediatrician: ___________________ Phone Number: ___________________
Dentist/Orthodontist: ___________________ Phone Number: ___________________
Preferred Medical Facility: ____
Insurance Company: ____
Policy/Group Number: ___________________ Policy Holder: ____________________

Executed this __________ day of ____________________, 20___.

___________________________ ____
Witness Signature of Parent/Guardian

___________________________ ____
Witness Signature of Parent/Guardian